The North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services works with partners to reduce the impact of behavioral health conditions in communities throughout the state. We review state-funded behavioral health initiatives that provide support to military personnel and their families, with special attention to public services and co-location efforts.

Substance use disorders, poor emotional health, and mental illness yield increased treatment costs for persons with comorbid physical diseases and are associated with some of the most substantial disability-related burdens faced by individuals, organizations, and countries worldwide [1]. The mission of the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) is to work with its partners to reduce the impact of these and other conditions, including traumatic brain injury, in communities throughout the state. Behavioral health services are essential services that address the whole health of the citizens of North Carolina, including military service members, veterans, members of the armed forces reserves and National Guard, and their families. Individuals in the military, veterans, and their families have served the United States, and it is the nation’s responsibility to ensure that the help they need will be available to them. The Department of Veterans Affairs (VA) has the lead on providing services to veterans, and the Department of Defense has military medical facilities across the nation. Both agencies support the Defense and Veterans Brain Injury Center. There remains, however, a critical role for state agencies in supporting the health of military families.

The DMHDDSAS, in collaboration with the Substance Abuse and Mental Health Services Administration (SAMHSA), has adopted the mission to facilitate innovative community-based solutions that foster access to evidence-based prevention, treatment, and recovery support services for military service members, veterans, and their families. The DMHDDSAS hosted a team representing its military and civilian partners and, on 2 occasions, participated in national policy academies to develop an action plan for North Carolina. The DMHDDSAS, under the direction of the governor and the General Assembly, is making access to care a priority, when care is appropriate. The DMHDDSAS is working to ensure that service systems in North Carolina are well prepared, through coordination and training, to meet the needs of the military, making military service members eligible for state-supported services when other benefits are not available or accessible. Additionally, all crisis support systems are available on demand to military service members in all 100 counties in the state. The focus of the collaboration is on posttraumatic stress disorder (PTSD), suicide, the increasingly acknowledged problem of drug misuse, and mild and moderate traumatic brain injury.

The North Carolina system of care is coordinated by 21 local management entities (LMEs) that work with providers across the state. Coordination between LMEs and community providers is important because it is estimated that only 30% to 40% of veterans who meet eligibility criteria for health care seek such care at VA facilities [2]. The DMHDDSAS has to work with the system to be prepared to address problems related to service members, veterans, and their families for the long term. Troubling issues related to trauma, addiction, and the effects of head injury can arise years after the event. Family members throughout North Carolina may also require services for mental health or substance use issues related to the service of their family member, or they may seek assistance for the care of service members who have PTSD, addiction, or head injury.

The DMHDDSAS offers a voucher program that provides National Guard members with free substance abuse assessments and trains practitioners about substance use disorders and the military. The DMHDDSAS has participated with SAMHSA to develop state plans and design support for a suicide-intervention program through the North Carolina
Challenges to Providing Services to North Carolina Veterans Who Have Traumatic Brain Injury

Marilyn Lash, Janice White, Sandra Farmer

North Carolina is currently at a critical crossroads for meeting the needs of service members and veterans with traumatic brain injuries (TBIs). On one path are the increasing numbers of service members with TBI, often the result of blast-related injuries received during the conflicts in Iraq and Afghanistan. TBIs present complex challenges for identifying, assessing, and meeting needs for treatment and services, because of the wide-ranging injury severity and physical, cognitive, behavioral, and emotional sequelae. The current population of veterans with TBI is larger than ever and involves a unique mix of active duty military, National Guard, and reserve personnel.

On the other path are the approximately 160,000 civilians with TBI in North Carolina, who also face the challenges of living with the effects of TBI. These individuals have learned that access to informed, coordinated medical and other community neurobehavioral services is limited and fragmented. In contrast to veterans, who are eligible for extensive Department of Veterans Affairs (VA) and TRICARE benefits, civilians face limitations associated with private insurance or managed care, and some have no insurance.

Providers of brain-injury care and support are also at the intersection of this crossroads. North Carolina has a severe shortage of providers who specialize in TBI care, and funding continues to be a roadblock. But the crisis is about more than funding. The lack of neurobehavioral services is the major unmet need identified by both civilians and service members who have experienced TBI, largely because North Carolina lacks an integrated neurobehavioral system of TBI care and services. There is no infrastructure designed to foster the development of programs, the number of qualified providers is insufficient, and reimbursement rates are not commensurate with the specialized costs of neurobehavioral services.

When service members and veterans leave the VA and the Department of Defense systems of care and return to their homes and communities, the next phase of rehabilitation and reintegration begins. This is where their needs intersect with those of civilians, as they search for services and supports in their local communities—whether it be for family counseling, job retraining, cognitive training, day programs, or home modifications.

The Brain Injuries Advisory Council of North Carolina and the Brain Injury Association of North Carolina are leading the way to develop an integrated system of community services for all persons with brain injury. These groups are working closely with the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, which is the designated lead state agency for TBI. People with neurobehavioral difficulties face significant community-level challenges. As reported in the National Association of State Head Injury Administrators’ (NASHIA’s) State of the States 2006 Panel on Neurobehavioral Issues, “Individuals with serious behavior disorders after TBI have traditionally been considered difficult to support in community settings and,

North Carolina has worked to improve care for all of its citizens, including those who served the nation as a member of the military. One avenue of improvement is being investigated by the CEIC, whose work addresses the disconnection between mental health and physical health, a by-product of the US health-care system’s payment system. This disconnection has made access to timely mental health services and coordinated care difficult for residents in North Carolina and the United States and has exacerbated the stigma many patients may feel about seeking mental health services. While the VA has led the way in integrating mental health care and physical health care at VA facilities, the public and private health systems have lagged in efforts to help patients who have mental and physical conditions. In 2006, professional organizations, state agencies, consumer groups, and others joined together to create the training program, clinical tools, and practice-based demonstration projects to enable primary care practices to integrate a mental health or substance abuse provider into the practice. This integration could be as minimal as an agreement to share patient care between a primary care practice and a mental health or substance abuse provider in the same region, or it could be as complex as the full integration of the behavioral health or primary care provider into the practice’s teams of
Therefore, place a disproportionate burden on public health systems. The absence of effective intervention and ongoing support...results in a threat to the safety of self and others” (NASHIA, unpublished data, 2006).

Emotional and behavioral challenges after TBI can include (1) impaired control of behaviors and emotions (eg, outbursts, aggression, anxiety, depression, or irritability), (2) verbal and/or physical disinhibition or impulsivity and increased frustration, (3) impaired physical activity (eg, hyperactivity or lethargy), (4) impaired self-management and self-regulation (eg, diminished problem-solving ability), and (5) impaired processing and interpreting of verbal and/or nonverbal communication.

Inadequate and underfunded brain-injury services and programs in North Carolina can result in inappropriate placement and programming, rather than appropriate diagnosis and treatment planning, for people with neurobehavioral challenges. Typical outcomes, placements, and services include the correctional system, psychiatric hospitals, substance abuse services, vocational rehabilitation, community-supported living, institutions (eg, intermediate care facilities for people with mental retardation and skilled-nursing facilities), and homelessness (TBI is estimated to occur in 30% of the homeless population). While some placements (eg, vocational rehabilitation, substance abuse services, and community-supported living) are appropriate, they are often unsuccessful because the underlying neurobehavioral issues have not been addressed. For effective delivery of services, including differential diagnoses and appropriate treatment planning, providers must have a sufficient level of expertise in brain injury.

Acknowledged best practices for treating people with brain injuries include (1) evaluations by a neuropsychologist, neuropsychiatrist, and physiatrist (specialized rehabilitation physicians), to assess functional abilities and the need for appropriate services; (2) evaluations by other rehabilitation professionals (eg, physical therapists, occupational therapists, speech-language pathologists, vocational rehabilitation counselors, social workers, and nurses), as needed; (3) person-centered, family-centered planning; (4) personal and medical histories from the injured person, as well as personal histories from their family members, friends, or coworkers; and (5) environmental supports for skill development and promotion of independence.

Recommended innovations in community care to meet the needs of returning military service members with TBI include accurate TBI screening; community-based neurobehavioral rehabilitation programs; a hospital-based “booster” approach; crisis stabilization; a mobile-team approach to activities such as assessment, crisis management, intervention, education, and mentoring; a consultation approach, including telehabilitation; cross-systems training; and family support and training. NCMJ


Address correspondence to Ms. Sandra Farmer, Brain Injury Association of North Carolina, 2113 Cameron St, Ste 242, Raleigh, NC 27605 (sandra.farmer@bianc.net).
health care settings for patients with physical and mental health conditions, but also to ensure that the care provided is consistent and evidence based, thereby assuring better patient care and outcomes.

This new collaboration between the Department of Health and Human Services’ agencies and contractors will, together with the military, continue to develop models for effective coordination of care for service members, veterans, and their families. NCMJ

Flo Stein, MPH chief, Community Policy Management Section, Division of Mental Health, Developmental Disabilities and Substance Abuse Services, North Carolina Department of Health and Human Services, Raleigh, North Carolina.

Michael Lancaster, MD director of behavioral health care, North Carolina Community Care Network, Raleigh, North Carolina.

Susan Yaggy, MPA president and chief executive officer, North Carolina Foundation for Advanced Health Programs, Raleigh, North Carolina.

Regina Schaaf Dickens, EdD, LCSW program director, North Carolina Center of Excellence for Integrated Care, North Carolina Foundation for Advanced Health Programs, Raleigh, North Carolina.

Acknowledgments
Potential conflicts of interest. All authors have no conflicts of interest.

References


Takeout can eat up your savings.

Pack your own lunch instead of going out. $6 saved a day x 5 days a week x 10 years x 6% interest = $19,592. That could be money in your pocket. Small changes today. Big bucks tomorrow. Go to feedthepig.org for free savings tips.